Care Management Connection

A publication of the Michigan Care Management Resource Center

February, 2017

Volume 2 Issue 2

The Role of Primary Care in the Non-pharmacological Management of COPD

The diagnosis of Chronic Obstructive Pulmonary Disease (COPD) in the primary care setting can be complex, as many symptoms are similar to asthma and heart disease. In many cases COPD therapy aims to relieve symptoms, where asthma treatment is directed at treating inflammation. For patients over 40 years old presenting with respiratory symptoms or a history of frequent respiratory infections, a full comprehensive assessment including patient history, physical exam and pre/ post-bronchodilator spirometry should be conducted.

Care managers should use proactive questions during the assessment including subjective information, as symptom reporting may affect diagnosis. One example may be a patient stating they can perform their usual activities, however with proactive questioning, they may admit that their "usual" activity became more limited than activity achieved three or five years ago. Several studies have suggested the use of a questionnaire to assist in providing measures of the symptomatic impact of COPD. The Global Initiative for Chronic Obstructive Lung Disease or GOLD has examples of questionnaires. For more information **Click Here.** Health and education includes information on avoiding risk factors for disease progression and exacerbations including the use of tobacco. The primary care practice should be actively involved in providing smoking cessation support. In addition, the emphasis on treatment plan adherence is significant; 40 to 60 percent of patients do not adhere to their prescribed regimen. A plan should be developed which the patient can easily follow and is cognizant of their life in their community setting. A study published in the Nordic College of Caring Science looked at the effects of COPD self-management education at a nurse-led primary care clinic. The study was comprised of two groups, both groups received standard care, however patients in the intervention group were offered additional visits with nurses who were specialized in COPD and group education. The purpose of these visits was to increase the patient's self-care ability and their knowledge of COPD. As a result, patients in the intervention group stated a reduction in respiratory distress symptoms, increased physical activity, improved psychosocial health, and increased knowledge of COPD. The intervention group showed improvement in health and reduced costs. For more details on this study **Click Here.**

There are many non-pharmacological strategies for the treatment of COPD. One of those, pulmonary rehabilitation, is an evidenced based, multidisciplinary, and comprehensive intervention for patients who have chronic respiratory disease and have decreased daily life activities. Some aspects of pulmonary rehabilitation may include: supervised exercise training, strength and conditioning, and inspiratory muscle training as well as nutrition counseling, and self-management education. GOLD states benefits include increased exercise capacity, reduced dyspnea, improved quality of life, and decreased health care utilization. Care mangers when working with patients should consider this a component of the patient's care plan. Overall goals are to reduce symptoms, and increase physical and emotional participation in everyday activities.

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UPCOMING EVENTS

VIEW OUR UPCOMING COURSES

Click on the dates below to register for MiCMRC Complex Care Management Courses:

March 20-23, 2017, Lansing

April 24-27, 2017, Lansing

MiCMRC CARE MANAGEMENT EDUCATIONAL WEBINAR

Date and Time: Wednesday March 15th, 2017 2-3pm
Title: Team Based Care

REGISTER

The Michigan Care Management Resource Center supports ambulatory practices statewide to implement and build upon Patient-Centered Medical Home (PCMH) and PCMH Neighborhood (PCMH-N) capabilities related to care management, population management, self-management support, and care coordination. MiCMRC provides foundational and longitudinal curriculum, tools and resources to assist practices with developing a sustainable, evidence-based clinical model for care management activities. Support for MiCMRC is provided by Blue Cross Blue Shield of Michigan Value Partnerships program.

Nursing and Social Work continuing education opportunity. For more information visit www.micmrc.org/continuing-ed

MiCMRC Questions?

For questions please **Contact Us**

Share Your Success Stories

Submitting your success story is as easy as clicking on the following link:

Share Your Success Story

For help submitting your success story contact us at http://micmrc.org/contact-

Michigan Care Management Resource Center Approved Self-Management Support Training Programs – Update

For information about MiCMRC approved self-management programs please see the document titled "Care Management Resource Center Approved Self-Management Support Training Programs" at **www.micmrc.org**

This document includes details for each MiCMRC approved self-management program: location, objectives, modality, resources, course date/criteria to schedule, trainer qualifications, certification/CEs, and cost. For questions please submit to: **micmrc-requests@med.umich.edu**

Care Management Billing Resources

MiCMRC now offers quick access to Care Management billing resources! Visit Click Here to access:

SIM

- SIM PCMH Care Management and Care Coordination Tracking Codes

Blue Cross Blue Shield of Michigan

- Blue Cross PDCM Medicare Advantage Billing Guidelines August 2014
- Blue Cross PDCM Commercial Billing Guidelines June 2016
- Pars IVR WebDENIS for PDCM

Priority Health

- Care Management Billing and Coding

CMS

- Centers for Medicare & Medicaid Services, Chronic Care Management Services Fact Sheet December 2016
- Centers for Medicare & Medicaid Services, Transitional Care Management Services Fact Sheet, March 2016

Multi-Payer

- G/CPT code Summary— COMING SOON
- G/CPT Documentation Summary— COMING SOON

Michigan Care Management Resource Center Announces New eLearning:

Online Basic Care Management Program

The Michigan Care Management Resource Center is proud to announce an interactive online program, focused on building care management skills and quick tools for daily work. The online eLearning series is open to all care managers and physician office practice team members at no cost. Learn at your pace and at a time convenient for you!

New in 2017, this online eLearning opportunity is designed for busy care managers and ambulatory care team members. The Basic Care Management Program consists of a series of online, interactive modules. Each module has brief 15-30 minute lessons; ideal for the busy learner.

When you participate in the eLearning modules you are joining care managers and office practice team members across the state from many practices and physician organizations, building core skills and improving the care delivered to their patients.

Each module will offer continuing education contact hours for both nursing and social work. Modules available beginning February 28, 2017 include:

- *Medication Management*
- *Introduction to Advance Care Planning and Palliative Care*
- *Transition of Care*
- *5 Step Process (Coming soon!)*

To access the eLearning Basic Care Management Modules visit **www.micmrc.org**

CMRC Website Offers New Chronic Condition Pages!

New in 2017 the Michigan Care Management Resource Center in an easy to access format offers chronic condition pages. Care Managers can now access tools and resources specific to asthma, diabetes, heart failure and hypertension, COPD.

The information contained within these chronic disease pages is designed to:

- Help care managers assist patients who face difficulty from specific chronic conditions
- Provide a framework for care management interventions
- Present various resources dedicated to the education of both the care manger and the patient
- Provide quick access to tools used in patient care setting

To learn more about these specific chronic conditions **Click Here**.

Each chronic disease page includes the following:

- Disease definition
- Evidenced based guidelines
- Action plan
- Care management interventions
- Patient interventions
- Care management quick tools
- Patient handouts
- Care management learning resources

MiCMRC Complex Care Management Course Registration – 2017 Updates

New in 2017 The MiCMRC Complex Care Management (CCM) course:

- **Open to all care managers!**
- **Has been updated to include new content!**
- **No course fee!**
- **Provides Social Work and Nursing CE's!**

The MiCMRC Complex Care Management course is designed to prepare the healthcare professional for the role of Complex Care Manager. Course content is applicable to all care managers in the ambulatory care setting, working with complex patients. The MiCMRC Complex Care Management Course (CCM) curriculum provides the framework for the complex care management role, foundational elements of integration into the ambulatory care setting, and development of complex care management skills.

***NEW FOR 2017: No fee for the MiCMRC CCM Course*. Also, due to the numerous care management programs in 2017, MiCMRC is now *requiring* the PO leader, practice manager or attendee's direct manager to register the care manager for the Complex Care Management Course.** This will facilitate accuracy of completion of the course registration fields and access to longitudinal resources for your staff.

The training format for MiCMRC CCM course consists of: a one-hour introductory live webinar, two days for recorded webinar self-study (approximately 6 hours of self-study) and two days of in-person classroom instruction.

****For High Intensity Care Model Managers (HICM) ONLY- *New*** for 2017, HICM participants are required to complete the MiCMRC CCM course and two subsequent HICM self-study modules that provide the additional specific information for the HICM program. **For HICM team members who completed the HICM course prior to 1/2017—No additional training is required**

NOTES: If you have 15 or more care managers in your area and would like the MiCMRC team to provide a regional training at your location please submit your request to: **micmrc-ccm-course@med.umich.edu**

Upcoming course dates and course registration:

March 20-23,2017 - Lansing Introductory Webinar March 20th, 2017. Total six-hour self-study modules and post-tests March 20-21, 2017. In person training March 22-23, 2017. NOTE: Registration deadline: March 16th, 2017.

April 24-27, 2017- Lansing Introductory Webinar April 24th, 2017. Total six-hour self-study modules and post-tests April 24-25, 2017. In person training April 26-27, 2017. NOTE: Registration deadline: April 20th, 2017.

Register here: **http://micmrc.org/training/micmrc-complex-care-management-course/registration**

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Nutrition is another important piece of COPD management. Those patients that are underweight or malnourished have an increased risk for exacerbations and mortality. In addition, obesity can present a risk as well. Nutritional supplementation in underweight and malnourished patients has been shown to promote weight gain, improve skinfold thickness and increase respiratory muscle strength. Care managers can connect with nutrition and dietary counseling which can be appropriate strategies for patients who need to gain or lose weight and both with making beneficial food choices.

Patient education should be tailored to the patient's needs and will vary based on the severity of disease. Goals for education should not only include knowledge of the disease but how to cope with it as well. While education may not improve their pulmonary function, it may improve their quality of life.

The Table below looks at topics for patient education based on severity:

For all patients Information and advice about reducing risk factors, including[1]: • exposure to tobacco smoke, especially for people with asthma • occupational exposure to dusts and chemicals • exposure to indoor and outdoor air pollutants
Grade 1 (Mild COPD) through Grade 3 (Severe COPD) Above topic, plus: • Information about the nature of COPD • Instruction on how to use inhalers and other treatments • Recognition and treatment of exacerbations • Strategies for minimizing dyspnea
Grade 4 (Very Severe COPD) Above topics, plus: • Information about oxygen treatment • Advance directives and end-of-life decisions

(CMAG. Chronic Obstructive Pulmonary Disease v2)

For More Information regarding COPD:

Global Initiative for Chronic Obstructive Lung Disease (GOLD)2017

Yawn, B.P. 2011. Optimizing chronic obstructive pulmonary disease management in primary care. *Southern Medical Journal*. 104 (2):121-127. Retrieved from **http://www.medscape.com/viewarticle/736747**

Efraimsson, E.O., Hillervik, C. PhD, & Ehrenberg, A. PhD. 2008. Effects of COPD self-care management education at a nurse-led primary health care clinic. *Scandinavian Journal of Caring Science*.22:178-185. Retrieved from **http://www.diva-portal.org/smash/get/diva2:523416/FULLTEXT03.pdf**

Frasier, K. RN 2015. CMAG. Chronic Obstructive Pulmonary Disease v2. Care Management Society of America.

MiCMRC Educational Recorded Webinar: Introduction to COPD **Click Here**

Increasing Practice Efficiencies, a Top Priority for Alcona Health Centers

Submitted by Kathleen Dunckel, MD, Physician Champion, Alcona Health Centers

Situation: Alcona Health Centers (AHC) were experiencing inefficiencies in closing gaps in care due to inadequate staffing, lack of consistent workflows, and a failure to utilize the full potential of the electronic medical record. In addition, inconsistent outreach to patients and documentation in the EMR hindered the communication of the clinical staff. Finally, redundancy existed between their Quality Improvement/Quality Assurance (QI/QA) committee workgroups, and the work of a newly formed Care Management Department.

Strategy: AHC's care connectors, primarily LPNs, were incorporated into the Care Management Department to cover most, if not all, of the clinic sites. A monthly meeting with the care connectors in addition to the department-wide meeting was instituted to help address specific care connector issues. Representatives from payers attended to explain their company's requirements and methods of reporting (i.e. online/fax.)

Karen Koenig RN, Care Management Department Manager, developed a consistent workflow for the care connectors which included a monthly review of insurance reports with the support of an **"insurance calendar"**. This calendar insured that reports from all payers are worked every month and that gaps are closed if appropriate documentation is in the patient record. Patients are contacted if a service is needed and a non-billable chart entry is created to document the outreach. If unable to be reached by phone, a letter is sent to the patient and a copy is filed in the EMR. In addition, with the establishment of a new Health Information Department, AHC has more robust and accurate use of a Clinical Events Manager feature within the EMR. Alerts appear for needed services when a patient's chart is first opened, allowing gaps to be identified by medical support staff, providers and/or care connectors and addressed at point-of-service.

Additional barriers became evident as the above changes took place. For instance, patients were not showing up for the appointments scheduled via phone by the care connector. Care connectors were coached on how to explore the patient's reasons for declining a service. Issues such as lack of insurance or transportation could then be addressed with an outreach and enrollment specialist or community health worker. The importance of respecting a patient's right to refuse was also emphasized.

There were many recognized improvements. The status of the missed opportunities workgroup of the QI/QA committee was changed to "Monitoring" largely due to the success of the care connectors. In addition, every gap is addressed with the insurance carrier monthly, allowing flexibility to correct deficiencies in a timely manner as they are identified, rather than focus on a few selected measures for an entire year. These changes have led to BCBSM, Molina and Meridian health plans reporting improvements in closing gaps in care.

For more information on this success story or closing gaps in care please contact: Karen Koenig @ **KKoenig@alconahc.org**